OKLAHOMA
State Department
of Health

Delivery via email to: Cpotterwilhelm@brookdale.com

January 16, 2026

License Number: AL1401

Chris Wilhelm, Administrator
Brookdale Norman
1701 East Alameda
Norman, OK 73071

RE: Survey Event ID: BEC111

Dear Mr. Wilhelm:

On **December 29, 2025**, agents from our office concluded a State Licensure survey with complaints at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **December 29, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to OSDH.LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Brookdale Norman**
Address: **1701 East Alameda**
City, State, Zip: **Norman, OK, 73071**
Provider #: **AL1401**
Complaint #: **OK00085272**
Investigation Date(s): **12/22/25, 12/23/25, and 12/29/25.**

ALLEGATION(S)
The center failed to ensure residents had the right to make choices related to their care.
The center failed to ensure residents were provided sufficient nutrition to prevent weight loss
The center failed to ensure residents were not neglected, or coerced.

An unannounced on-site investigation was initiated 12/22/2025 at 11:45 a.m.

A sample of 7 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident rooms and common areas were observed for staff assistance and call lights. Residents were observed for being both assisted and tending to their own needs.

Resident records were reviewed including assessments, care plans, and contracts. Weights and meals were reviewed.

Residents were interviewed related to the provisions of choices about their care, nutrition, and coercion. They were asked if they had any concerns with their care.

Staff members were interviewed related to the provisions of resident choices, care, and neglect.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health

OKLAHOMA
State Department
of Health

Long Term Care Service

Date report completed: 12/29/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Brookdale Norman**
Address: **1701 East Alameda**
City, State, Zip: **Norman, OK, 73071**
Provider #: **AL1401**
Complaint #: **OK00088033**
Investigation Date(s): **12/22/25, 12/23/25, and 12/29/25.**

ALLEGATION(S)
The center failed to ensure medications were administered according to the physician orders
The center failed to ensure fall hazards were identified in an effort to decrease the risk for falls
The center failed to ensure assistance with activities of daily living was provided in a timely manner.
The center failed to ensure call lights were answered in a timely manner.

An unannounced on-site investigation was initiated 12/22/2025 at 11:45 a.m.

A sample of 7 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident rooms and common areas were observed for accident hazards, staff assisting residents with care needs.

Resident records were reviewed including assessments, care plans, contracts, orders, notes, facility policy and procedures.

Residents were interviewed related to the care they receive and the environment.

Staff members were interviewed to the provision of providing care and the process for medication administration.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 12/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1401	A. BUILDING: _____ B. WING _____	C 12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORMAN	1701 EAST ALAMEDA NORMAN, OK 73071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00085272 and #OK00088033) was conducted on 12/22/25, 12/24/25, and 12/29/25. Deficiencies were cited as a result of the survey. Facility Census: 32 Listed below are abbreviations that will be used throughout this survey. ACMA- advanced certified medication aide ED- executive director ER - extended release HCL- hydrochloride MAR- medication administration record MEQ- milliequivalent MG- milligram	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure food temperatures from the steam table were obtained to ensure temperature was maintained above 135 degrees prior to meal service for 1of 1 meal service observed. The ED identified 32 residents resided at the center. Findings:	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 391	Continued From page 1 On 12/23/25 at 11:51 a.m., the main dish (beef,cabbage, and cheese) was observed being removed from the oven and the temperature was not checked. On 12/23/25 at 11:54 a.m., the main dish was observed being placed on the steam table and the temperature was not checked. On 12/23/25 at 11:55 a.m., the mashed potatoes were observed being removed from the stove and placed in a pan and put on the steam table and the temperature was not checked. On 12/23/25 at 11:58 a.m., the green beans were observed being removed from the stove and placed in a pan and put on the steam table and the temperature was not checked. On 12/23/25 at 12:06 p.m., meal service started and the temperatures of the food from the steam table were not checked prior to being served. On 12/23/25 at 12:14 p.m., the dining service coordinator was asked how they ensured the food reached proper cook temperature and was maintained. The dining service coordinator stated they normally took temperature of the food, but they did not. On 12/23/25 at 12:30 p.m., the ED stated the dining service coordinator did not have one on one training.	C 391		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the	C 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1401	A. BUILDING: _____ B. WING _____	C 12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORMAN	1701 EAST ALAMEDA NORMAN, OK 73071

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C 940	Continued From page 2 needs of individuals with special diets. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure the dietician was notified and approved meal substitutions for 1 of 2 meal observations. The ED identified 32 residents resided in the center. Findings: On 12/23/25 at 11:22 a.m., follow up visit to the kitchen for meal preparation observation showed the cook had a cabbage, beef, and cheese casserole was in the oven. A policy titled "Menu Planning," dated 10/2024, read in part, "Any menu changes should be done within the menu program to ensure nutritional adequacy and regulatory compliance are maintained."..."Unanticipated menu changes (i.e. unavailable ingredient, quality concerns) should be recorded on the Menu Substitution Log including date, meal, original and substituted menu item, and the reason for the substitution."... "The recipes and therapeutic diet modifiers for all menu items, including substitutes should be printed and available for associates." A signed menu, dated 12/15/25, showed the food to be served for 12/23/25 as the light meal of garden vegetable soup, grilled chicken salad, classic pea salad, and pound cake. There was no log or notification documentation the dietician was notified of the menu change.	C 940		

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C 940	Continued From page 3 On 12/23/25 at 11:34 a.m., the dining service coordinator stated the menu being served was changed to a recipe from a resident because they ordered the food too late and it had not arrived yet. They stated the truck order was to arrive the next day. On 12/23/25 at 11:46 a.m., the dining service coordinator stated they did not notify the dietician with the menu change, but tried to keep it as balanced as possible. On 12/23/25 at 2:20 p.m., the ED and registered nurse consultant stated their policy was to put substitutions on a sheet, but the cook did not know that. They stated they were not required to contact the dietician. They stated there was a policy for it and they needed to find it. On 12/23/25 at 3:00 p.m., the ED provided a blank copy of the "Menu Substitution Log" that was to be used. It was blank.	C 940		
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure residents received their medication according to physician's orders for 3 (#2, 4, and #5) of 8 sampled residents reviewed for medications. The ED identified 32 residents resided at the	C1920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1401	A. BUILDING: _____ B. WING _____	C 12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORMAN	1701 EAST ALAMEDA NORMAN, OK 73071

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C1920	Continued From page 4 center. Findings: 1. A physician's order, dated 10/10/25, showed amantadine HCL (Parkinson's medication for tremors) 100 mg two times a day. Resident #2's November 2025 MAR showed diagnosis of Parkinson's disease. The MAR showed a chart code of "20" instead of a check mark for amantadine HCL on 11/12/25 at 11:00 a.m., and on 11/13/25 at 7:00 a.m., and 11:00 a.m. On 12/29/25 at 10:58 a.m., ACMA #1 stated the number "20" on the MAR meant the medication treatment was not available. ACMA #1 reviewed the MAR and stated the amantadine was not administered. They stated the reason was the medication was not available. 2. A physician's order for Resident #5, dated 11/07/24, showed Valproic Acid (mood stabilizer) 250 mg one time a day. Resident #5's November 2025 MAR showed diagnoses which included bipolar disorder and epilepsy. A physician's order for Resident #5, dated 11/07/25, showed Valproic Acid 250 mg give two capsules at bedtime to equal 500 mg. Resident #5's December 2025 MAR showed a chart code of "20" instead of a check mark for: a. Valproic Acid at 6:00 p.m. on 12/22/25 and 12/23/25, and b. Valproic Acid at 7:00 a.m. on 12/24/25.	C1920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1401	A. BUILDING: _____ B. WING _____	C 12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1920	Continued From page 5 On 12/29/25 at 11:02 a.m., ACMA #1 reviewed the MAR and stated the Valproic Acid was not administered. They stated the reason was the medication was not available. 3. A physician's order for Resident #4, dated 12/09/22, showed Nexium (stomach acid reducer) 40 mg one time a day. A physician's order for Resident #4, dated 01/21/24, showed magnesium chloride (supplement) 400 mg one time a day. A physician's order for Resident #4, dated 07/09/25, showed potassium chloride ER (supplement) 10 meq two times a day. A physician's order for Resident #4, dated 07/09/25, showed Allopurinol (uric acid reducer) 100 mg two times a day. A physician's order for Resident #4, dated 08/05/25, showed Tylenol (pain medication) 500 mg two times a day. Resident #4's November 2025 MAR showed diagnoses which included malignant neoplasm of the bladder, gout, and chronic kidney disease. The MAR showed a chart code of "20" instead of a check mark for: a. magnesium oxide at 9:00 a.m. on 11/24/25, 11/25/25, 11/26/25, and 11/27/25, and b. potassium chloride ER at 9:00 a.m. on 11/26/25, 11/27/25, and 11/30/25; and at 9:00 p.m. on 11/29/25. Resident #4's December 2025 MAR showed a chart code of "20" instead of a check mark for: a. magnesium oxide at 9:00 a.m. on 12/01/25, 12/02/25, and 12/03/25,	C1920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1401	A. BUILDING: _____ B. WING _____	C 12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1920	Continued From page 6 b. potassium chloride ER a 9:00 a.m. on 12/01/25, 12/02/25, and 12/03/25, c. Nexium at 9:00 a.m on 12/15/25, 12/18/25 through 12/21/25, and 12/24/25 through 12/28/25, d. Allopurinol at 9:00 a.m. on 12/01/25 through 12/03/25, and e. Tylenol at 9:00 a.m. on 12/01/25 and 12/02/25. On 12/29/25 at 11:04 a.m., ACMA #1 reviewed both the November 2025 and the December 2025 MAR for Resident #4 and stated the above mentioned medications were not administered by reason of the medications not being available. ACMA #1 stated Resident #2, 4, and #5 did not receive their medications according to the physicians order.	C1920		

OKLAHOMA
State Department of Health

Delivery via email to: cpotterwilhelm@brookdale.com

February 2, 2026

License Number: AL1401

Mr. Christopher Potter Wilhelm, Administrator
Brookdale Norman
1701 East Alameda
Norman, OK 73071

RE: Survey Event BEC111

Dear Mr. Wilhelm:

On **December 29, 2025**, a Licensure inspection with complaints was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **February 28, 2026**.

We will conduct a revisit for your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/28/2026** **Facility Name:** Brookdale Norman **License Number:** AL1401 **Survey Event ID:** BEC111 **Date Survey Completed: 12/22/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391 SS=F	Based on: Based on observation and interview, the centerfailed to ensure food temperatures from thesteam table were obtained to ensure temperaturewas maintained above 135 degrees prior to mealservice for 1of 1 meal service observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Norman regarding the Statement of Deficiencies dated 12/29/2025. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Food Temperature log binder has been set up and placed in the steam table area of the dining room.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	DSC and Cook were in-serviced on Food and Beverage Temperature Control DS-04.010 Policy. New DSC was sent to a sister community for one on one training. Record keeping on approved Brookdale temperature log for each meal.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: Executive Director or designees will complete random weekly audtis DSC or designees will bring the Temp log into the Monthly meeting to ensure effectiveness. Temp log will be audited and monitored for 3months during the QA process.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/28/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required OAC 310:663-25-4(F)	**Date 1/30/2026**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/28/2026** **Facility Name:** Brookdale Norman **License Number:** AL 1401 **Survey Event ID:** BEC111 **Date Survey Completed: 12/29/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 940 SS=E	Based on: Based on observation, record review, andinterview, the center failed to ensure the dieticianwas notified and approved meal substitutions for1 of 2 meal observations.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Norman regarding the Statement of Deficiencies dated 12/29/2025. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	DSC was in-serviced on the Menu Planning policy and DSF005 Menu Substitution Log. Menu was reviewed for the rest of the week to ensure items were on hand to follow the menu.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All resident have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	DSC and Cook have been in-serviced on the Menu Planning policy and DSF005 Menu Substitution Log. Menus changes will be completed in the menu program. ED or designee will randomly audit meals to ensure they match the menu or substitutions are documented correctly if a change had to be made. Ensure the approved Brookdale Menu Substitution Log is utilized.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: ED or designees will randomly audit meals to ensure menu is followed. ED or designee will monitor any changes to the menu by reviewing the Menu Substiution log. DSC or designess will bring the Menu Substiution log to the monthly meeting. Changes will be recorded on the Menu Substiution log and keep with QA for 3 months.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/28/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required	**Date 1/30/2026**

OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/28/2026** **Facility Name:** Brookdale Norman **License Number:** AL 1401 **Survey Event ID:** BEC111 **Date Survey Completed: 12/29/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1920 SS=E	Based on: record review and interview, the centerfailed to ensure residents received theirmedication according to physician's orders for 3(#2, 4, and #5) of 8 sampled residents reviewedfor medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Norman regarding the Statement of Deficiencies dated 12/29/2025. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Center staff failed to ensure that residents received their medication as per doctor's orders. Missing med report will be ran randomly for review of missing meds and ordered as needed. This report will be reviewed by ED, HWD and or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents in the community have the potential to be affected but none were identified as being affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Center will randomly run missing med reports and review during daily stand up for effectiveness. In-service completed with med aides and nurses on medication and treatment availability policy.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: Medication Admin. Audit report will be ran weekly and reviewed for compliance by ED, HWD and or designee. HWD designee will bring the reports to monthly QA meeting to ensure effectiveness Audited records will be kept in POC binder and monitored during QA process for 3 months.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/28/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required	**Date 1/30/2026**
OAC 310:663-25-4(F)	

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department
of Health

Delivery via email to: Cpotterwilhelm@brookdale.com

March 3, 2026

License Number: AL1401

Mr. Christopher Potter Wilhelm, Administrator
Brookdale Norman
1701 East Alameda
Norman, OK 73071

RE: Survey Event BEC112

Dear Mr. Wilhelm:

On **March 3, 2026,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your relicensure survey with complaints on **December 29, 2025,** have now been corrected effective **February 28, 2026.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1401	A. BUILDING: _____ B. WING _____	R-C 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORMAN	1701 EAST ALAMEDA NORMAN, OK 73071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 03/03/26. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE